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F 000	INITIAL COMMENTS The following citation represent the findings of a Health Resurvey. The 2567 was sent electronically on 04/25/24.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 55 residents. The sample included 14 residents, with six reviewed for falls. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 40 remained free from avoidable falls when staff failed to provide R40 with the necessary equipment to ensure safety, including a call light and mobility devices, on two separate occasions which resulted in falls on both occasions. This placed the resident at risk for avoidable injury. Findings included: - R40's Electronic Medical Record (EMR) documented diagnoses of heart failure, hypertension (high blood pressure), atrial fibrillation (rapid, irregular heartbeat), and anxiety (mental or emotional reaction characterized by	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/25/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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apprehension, uncertainty, and irrational fear).

R40's "Admission Minimum Data Assessment" (MDS), dated 08/08/23, documented R40 had intact cognition, and required extensive assistance from two staff for bed mobility, transfers, ambulation, dressing, and toileting; R40 required extensive assistance from one staff for personal hygiene. The MDS further documented R40 had unsteady balance and no falls since admission.

The "Quarterly MDS," dated 02/06/24, documented R40 had intact cognition, required substantial assistance with toileting, dressing, and transfers, and required supervision with mobility. R40 did not ambulate. The MDS further documented R40 had a functional impairment in both lower limbs. R40 had two falls since the last assessment.

The "Fall Risk Assessments," dated 08/2/23, and 01/09/23 documented a moderate risk for falls.

R40's "Care Plan," dated 01/29/24 and initiated on 08/03/23, directed staff to ensure his walker and wheelchair are within his reach and easy access. The update, dated 08/22/23, directed staff to check on R40 frequently and ensure safety and call light placement. The update, dated 11/14/23, directed staff to place a call light box above the resident's bed and a clip to the call button to prevent any tripping hazard. The update, dated 01/09/24, directed staff the ensure R40's wheelchair was within reach before exiting the room.

The "Root Cause Analysis Investigation," dated 11/11/23 at 01:35 AM, documented R40 was

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found lying on the carpeted floor next to his bed, face down with his legs extended. His call light was next to him. R40 stated his call light was on the floor and he leaned over to retrieve it which caused him to roll out of bed. The investigation further documented R40 sustained a laceration to the top of his head, which required first aid. R40 was taken to the local hospital and the laceration was cleansed and glued. The staff were educated to ensure R40's call light was within reach before exiting the room.

The "Root Cause Analysis Investigation," dated 01/09/24 at 12:21 PM, documented R40 hollered for assistance and was found on the floor in his room. R40 stated he tried to get out of the recliner to use his walker to go to the bathroom, but both the walker and wheelchair were not within reach, and he stated he could not call for assistance because his call light was not within reach either. The staff was educated to ensure his call light and wheelchair were within reach before exiting his room.

On 04/15/25 at 08:29 AM, observation revealed R40 in the bathroom. Licensed Nurse (LN) H told R40 to use the grab bar beside the toilet to assist him in standing up. R40 stood up, LN H performed personal care then assisted R40 into his wheelchair. LN H pushed R40 by his recliner, gave him his call light, and told him to call if he needed assistance.

On 04/10/24 at 12:15 PM, Certified Nurse Aide (CNA) R stated R40 did not have any falls when she worked and said she always made sure R40 had his call light before she left the room and stated they are trained regarding abuse and neglect yearly.

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F 689	Continued From page 3 On 04/15/24 at 08:40 AM, LN H stated R40 called when he required assistance. LN H said R40 had not had any falls on her shift, and stated they have ongoing training regarding falls and abuse and neglect. On 04/15/24 at 02:14 PM, Administrative Nurse D stated, R40 should not have been left without access to his call light, staff were educated and another call light was placed where it would be accessible. The facility's policy "Falls" revised 10/12/22 documented that residents would be identified for risk of falls and interventions would be implemented to reduce the risk The facility failed to ensure R40 remained free from avoidable falls. This placed the resident at risk for injury.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		

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§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 55 residents. The sample included 14 residents, with one reviewed for hydration. Based on observation, record review, and interview, the facility failed to establish the physician-ordered fluid restriction for one resident, Resident (R) 40. This placed the resident at risk for dehydration (a harmful reduction in the amount of water in the body) or fluid overload (too much fluid in the body).

Findings included:

- The Electronic Medical Record (EMR) documented R40 had diagnoses of heart failure (the heart does not pump blood as well as it should), hypertension (high blood pressure), atrial fibrillation (rapid, irregular heartbeat), and anxiety (metal or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R40's "Admission Minimum Data Assessment" (MDS), dated 08/08/23, documented R40 had intact cognition. R40 required extensive assistance from two staff for bed mobility, transfers, ambulation, dressing, and toileting. R40 required set-up assistance for eating.

The "Quarterly MDS," dated 02/06/24, documented R40 had intact cognition. R40 required substantial assistance with toileting,

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dressing, and transfers and supervision with mobility. R40 required set-up assistance for eating.

R40's "Care Plan," dated 01/29/24 and initiated on 08/15/23 documented R40 was on a regular diet with an 1800 milliliter (ml) fluid restriction. R40 would receive 75 percent (%) of his fluid from nutrition (1350 ml), and 25% from nursing (450 ml). The care plan further directed staff to provide R40 with his choice of fluids at each meal and place them at his bedside.

The "Physician's Order," dated 12/07/23, directed staff to implement a fluid restriction for R40 of 1800 ml every 24 hours.

R40's "Treatment Administration Record" (TAR) for December 2023 lacked documentation the resident was on a fluid restriction.

R40's "TAR" for January, February, March, and April 2024 lacked documentation the resident was on a fluid restriction.

On 04/10/24 at 11:55 AM, observation revealed two 24-ounce (oz) mugs and a 20 oz disposable cup with coffee in it on R40's bedside table.

On 04/10/24 at 12:35 PM, Certified Medication Aide (CMA) M stated she had not known R40 was on a fluid restriction even though the fluid restriction was displayed on the face sheet of the EMR in bold letters. CMA M further stated she also worked the floor as a Certified Nurse Aide (CNA) and was unaware of the restriction.

On 04/10/24 at 12:45 PM, Licensed Nurse (LN) G stated she worked a couple of days a week and

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F 692	Continued From page 6 was unsure if R40 was on a fluid restriction or where staff would document fluid intakes. On 04/10/24 at 12:55 PM, Dietary BB stated she would be notified by her supervisor if a resident was on a fluid restriction and the supervisor would inform her how much fluid would be given at meals. Dietary BB stated she was unaware of R40's fluid restriction. On 04/15/24 at 02:14 PM, Administrative Nurse D verified R40's fluid restriction was never implemented by staff and said staff should have been monitoring R40's fluid intake. The facility's "Fluid Restrictions and Additions" policy, dated 09/22, documented that fluid restrictions were ordered by the physician, and dining services would adjust the resident's menu and nourishments accordingly. The amount of fluid for each item would be indicated on the resident's menu or tray ticket and nursing personnel were responsible for recording and monitoring the fluid intake. Dining services would provide 75% of the fluid restriction and nursing would provide 25% of the fluid restriction. The facility failed to establish a fluid restriction as ordered for R40. This placed the resident at risk for dehydration or fluid overload.	F 692		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting	F 699		

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for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 55 residents. The sample included 14 residents, with seven reviewed for behaviors. Based on observation, record review, and interview, the facility failed to complete a trauma-informed care assessment and failed to develop a comprehensive trauma-informed care plan for Resident (R) 35, who had a diagnosis of post-traumatic stress disorder (PTSD-psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture). This placed R35 at risk for unmet behavioral and mental health needs and retraumatization.

Findings included:

- The Electronic Medical Record (EMR) for R35 documented diagnoses of PTSD, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Admission Minimum Data Set" (MDS), dated 01/03/24, documented R35 had intact cognition and required supervision with toileting, transfers, and bathing. R35 required set-up assistance with personal hygiene; R35 was independent with mobility. The assessment documented R35 received antianxiety (a class of medications that calm and relax people) and

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antidepressant (a class of medications used to treat mood disorders) medication and had no behaviors.

R35's "Care Plan," dated 01/08/24 and initiated 01/05/24, documented R35 received psychotropic (medication used to treat mental illnesses) medication with the potential for drug-related complications from anxiety and depression. The plan directed staff to educate the family on potential risks, benefits, and alternatives, administer medication as ordered, and monitor for adverse side effects. The care plan lacked direction to staff on R35's trauma triggers and coping strategies.

R35's EMR lacked evidence a trauma-informed assessment was completed for R35 after admission.

The "Physician's Order," dated 12/27/23, directed staff to administer buspirone (an antianxiety medication), 5 milligrams (mg) by mouth twice per day for depression.

The "Physician's Order," dated 12/27/23, directed staff to administer Trazadone (an antidepressant medication), 50 mg by mouth at bedtime for depression.

The "Physician's Order," dated 01/08/24, directed staff to administer Lexapro (an antidepressant), 10 mg by mouth daily for depression.

On 04/10/24 at 09:38 AM, observation revealed R35 at a group activity actively participating.

On 04/10/24 at 12:20 PM, Certified Nurse Aide (CNA) R stated she had not been aware of R35's

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PTSD diagnosis and she was not informed of any triggers R35 would have or of her history.

On 04/11/24 at 09:46 AM, Licensed Nurse (LN) G stated she had not been aware of R35's diagnosis of PTSD and did not know what her triggers were. LN G stated R35 was quiet and did not have any type of behavior.

On 04/11/24 at 01:00 PM Social Services X stated she had completed a life stressor assessment on R35 when the resident was previously in the facility back in June 2023 but said she had not completed a trauma-informed care assessment for the most recent admission. Social Services X further stated she had not spoken with staff regarding R35's PTSD triggers due to R35's intact cognition and R35 was a very private person. Social Services X verified that she had not completed any care plan for R35 related to her mood and PTSD diagnosis.

On 04/15/24 at 02:15 PM, Administrative Nurse D stated she had provided the staff with education related to R35's PTSD and stated a care plan was just completed to assist staff in recognizing what triggered R35's PTSD and anxiety. Administrative Nurse D said she was not aware R35 needed to have a trauma-informed care assessment.

The facility's "Trauma Informed Care" policy, dated 10/12/21, documented the organization was committed to implementing trauma-informed approaches to the care provided and the organizational culture created for the residents of the community. The policy further documented a trauma-informed assessment would be completed within 72 hours of admission for initial

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F 699	Continued From page 10 screening of a history of trauma and it would determine if the resident had trauma-related symptoms. The assessment would be completed by Social Services, designee, or other licensed staff. The interdisciplinary team would discuss the findings to determine the resident's treatment plan including interventions to avoid re-traumatization and assist in identifying and managing trauma-related triggers. Staff would be trained and competency-tested on trauma-informed care during orientation, annually, and at any time deemed necessary by the supervisor. The facility failed to complete a trauma-informed care assessment and failed to develop a care plan for R35, who had a diagnosis of PTSD. This placed R35 at risk for unmet behavioral and mental health needs and retraumatization.	F 699		